Instructions for Submitting an Application

This is a competitive process. Fill out the application completely and follow instructions carefully.

1. Applications will only be accepted during the annual application period, August 1 through October 1. Applications postmarked after the deadline (October 1) will not be accepted.

2. The current fiscal year application form must be used for submission. The form title includes current grant cycle fiscal year (i.e. "Good For Use in 2005/06 Grant Period Only.")

3. Both the applicant and practice site must meet all eligibility requirements listed on the Fact Sheet at time of application.
   a. Applicant must be employed by an eligible practice site that has a current, approved site application on file with OSHPD.
   b. Applicant must complete contractual service time or pay severe default penalties
   d. Practice site must agree to match the loan repayment award on a dollar-for-dollar basis with non-federal funds.

4. The completed application package must include:
   a. A cover letter from the practice site verifying applicant's employment and including an agreement to match the award amount received;
   b. The completed application form with any required explanations attached;
   c. Thorough and detailed response to questions requiring narrative description of experience or education; and,
   d. A current lender balance statement for each loan to be included in the loan repayment.

5. Mail application package to:
   Karen Munsterman
   State Loan Repayment Program
   1600 9th Street, Room 440
   Sacramento, CA 95814

Applications received during open application period will be ranked according to predetermined evaluation criteria. Applications not initially selected for funding will be kept on file in ranked order. If, at a later time, funding becomes available, applicants already on file will be contacted to determine availability rather than introduce a new application cycle.

If you have questions, **send email** to the Program Administrator. **PLEASE DO NOT CALL TO INQUIRE ABOUT THE STATUS OF YOUR APPLICATION.** You will be notified as quickly as possible.

EVALUATION CRITERIA

- ANY QUESTION ON THE APPLICATION THAT ASKS YOU TO EXPOUND ON YOUR "YES" ANSWER ON AN ADDITIONAL SHEET OF PAPER IS ONE ON WHICH YOU WILL BE SCORED. BE THOROUGH AND DETAILED WITH YOUR ANSWER(S).

- OTHER FACTORS THAT MAY BE RELEVANT IN THE SELECTION ARE:

  1. Geographic distribution of SLRP awardees

  2. Distribution by discipline (Primary Care Physicians, Dentists, Mental Health Providers, Mid-level providers)

  3. Area of greatest unmet need (medical, dental, and mental health underservedness)

  4. Rural vs. Urban award distribution

Please note: Applications that are NOT selected for funding will be kept on file in ranking order. If, at a later time, additional funds become available, applicants will be notified and be given the opportunity to participate in the program.

OFFICE OF STATEWIDE HEALTH PLANNING AND DEVELOPMENT
NHSC/STATE LOAN REPAYMENT PROGRAM

PRIMARY CARE HEALTH PROFESSIONAL APPLICATION

GOOD FOR USE IN 2005/2006 GRANT PERIOD ONLY

SECTION I - PERSONAL DATA

Please type or print with ink

Applicant Name: _____

Home Address: _____

City: _____ State: _____ Zip + 4: _____

Day Phone: (_____) _____ Evening Phone: (_____) _____

Social Security #: _____ Birth Date: _____

1. Are you a United States citizen? ____Yes ____No
2. Do you have a current and unrestricted California license to practice your profession? ____Yes ____No
3. Are you free of unserved obligations for service? ____Yes ____No (If no, attach explanation)
   (i.e., Federal, State, local government, or other entity)
4. Are you free of judgments arising from Federal debt? ____Yes ____No (If no, attach explanation)
5. Are you delinquent with any court ordered child support? ____Yes ____No (If yes, attach explanation)
6. Have you had any cultural competency training? ____Yes ____No (If yes, attach explanation)
   (Communities studied i.e., Hmong, Russian, et. al.)
7. Are you fluent in any other language(s) besides English? ____Yes ____No (If yes, attach explanation)
   [Include basic medical language(s) training.]
8. Have you had training or work experience in a medical, dental, or mental health underserved area? ____Yes ____No (If yes, attach explanation)

SECTION II - GENDER/RACE/ETHNICITY DATA

Please check the appropriate items

___ Male ___ Female

___ American Indian or Alaska Native

___ Asian

___ Black or African American

___ Hispanic or Latino

___ Native Hawaiian or Other Pacific Islander

___ White

___ Other

SECTION III - HEALTH PROFESSION

Please check the appropriate item(s)

___ **M.D.** ___ **D.O.**

___ Family Physician

___ General Internist

___ General Pediatrician

___ Obstetrician-Gynecologist

___ General Psychiatrist

___ Physician Assistant

___ Nurse Practitioner

___ Certified Nurse-Midwife

___ Dentist (D.D.S.)

___ Dentist (D.M.D.)

___ Clinical/Counseling Psychologist

___ Licensed Clinical Social Worker

___ Mental Health Counselor

___ Licensed Professional Counselor

___ Marriage and Family Therapist

OFFICE OF STATEWIDE HEALTH PLANNING AND DEVELOPMENT
NHSC/STATE LOAN REPAYMENT PROGRAM

PRIMARY CARE HEALTH PROFESSIONAL APPLICATION
GOOD FOR USE IN 2005/2006 GRANT PERIOD ONLY

SECTION IV - HEALTH PROFESSIONAL EDUCATION

School: _____ Date of Graduation: _____

City: _____ State: _____ Zip + 4: _____

Postgraduate Training: _____ Year completed: _____

Board Eligible: _____ Board Certified: _____ CA License Number: _____

Certificate Number: _____

SECTION V - PRACTICE SITE

1. Applicant agrees to provide full-time 40 hrs./wk. (including a minimum of 32 hrs. direct patient care) at:

- Practice Site Name: _____ **Percentage of time** _____

  Address: _____

  City: _____ County: _____ Zip + 4: _____

- Practice Site Name: _____ **Percentage of time** _____

  Address: _____

  City: _____ County: _____ Zip + 4: _____

2. Practice Site Contact Person: _____

   Title: _____ Telephone No.: _____

3. Applicant agrees to provide full-time direct patient care, at the site(s) named above, for:

   _____ 2 Years _____ 3 Years _____ 4 Years

OFFICE OF STATEWIDE HEALTH PLANNING AND DEVELOPMENT
NHSC/STATE LOAN REPAYMENT PROGRAM

PRIMARY CARE HEALTH PROFESSIONAL APPLICATION

GOOD FOR USE IN 2005/2006 GRANT PERIOD ONLY

SECTION VI - EDUCATIONAL DEBT

All applicants must submit a current loan statement for each loan listed below. Each statement must contain the Applicant's name, account number, the principle and interest amounts and/or the payoff balance.

1. Loan Company Name: _____
("Payee")

Loan Company Address: _____
(Payee Address)

City: _____ State: _____ Zip + 4: _____

Account Number: _____ Loan Balance: $ _____

2. Loan Company Name: _____
("Payee")

Loan Company Address: _____
(Payee Address)

City: _____ State: _____ Zip + 4: _____

Account Number: _____ Loan Balance: $ _____

3. Loan Company Name: _____
("Payee")

Loan Company Address: _____
(Payee Address)

City: _____ State: _____ Zip + 4: _____

Account Number: _____ Loan Balance: $ _____

4. Loan Company Name: _____
("Payee")

Loan Company Address: _____
(Payee Address)

City: _____ State: _____ Zip + 4: _____

Account Number: _____ Loan Balance: $ _____

OFFICE OF STATEWIDE HEALTH PLANNING AND DEVELOPMENT
NHSC/STATE LOAN REPAYMENT PROGRAM

PRIMARY CARE HEALTH PROFESSIONAL APPLICATION
GOOD FOR USE IN 2005/2006 GRANT PERIOD ONLY

SECTION VI - EDUCATIONAL DEBT (Continued)

5. Loan Company Name: _____
("Payee")

Loan Company Address: _____
(Payee Address)

City: _____ State: _____ Zip + 4: _____

Account Number: _____ Loan Balance: $ _____

6. Loan Company Name: _____
("Payee")

Loan Company Address: _____
(Payee Address)

City: _____ State: _____ Zip + 4: _____

Account Number: _____ Loan Balance: $ _____

SECTION VII - CERTIFICATION

I certify that all statements made in this application are complete and accurate to the best of my knowledge. I understand that falsification will disqualify my application. I authorize representatives of the Office of Statewide Health Planning and Development to contact institutions holding any of the listed educational loans, educational institutions I attended, and employers to verify the accuracy of the information contained in this application.

Signature: _____ Date: _____

Please submit the application, and relevant loan statements, via the practice site contact person.

DO NOT WRITE BELOW THIS LINE

Application Received: _____ HPSA ID# _____ Cleared by NHSC: _____

Comments: _____